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CIRCULAR LETTER NO. 56

The Treatment of Gonorrhea

1. Circular Letter No. 19, Off Ch Surg, "The Treatment of Gonorrhea", 27 February 1945, is rescinded.

2. Diagnosis. The diagnosis of gonorrhea will be established according to the provisions of par 1a of Circular Letter No. 31, Off Ch Surg, "The Diagnosis and Reporting of the Venereal Diseases", 10 March 1944. Smear and/or culture for gonococci will be taken. Every effort will be made to establish the diagnosis of gonorrhea definitely before penicillin therapy is initiated.

3. Examination for concomitant evidence of syphilis. Administration of penicillin for gonorrhea to a patient with undiagnosed or undetected lesions which might be syphilitic is a reprehensible practice, and is strongly condemned. Complete examination of the skin and mucous membrane of patients with gonorrhea will be made prior to treatment, to determine that no lesions of early syphilis are present. In addition, blood for a Kahn test will be drawn, though it is not necessary to await the results of this test before proceeding with treatment for gonorrhea, providing the diagnosis of this disease is confirmed.

4. Treatment.

a. The initial treatment of gonorrhea will consist of a total of 200,000 units of penicillin, divided into five doses of 40,000 units each at intervals of two hours. An acceptable alternate method consists of four doses of 50,000 units each, at intervals of two hours. Whenever feasible, and providing no complications are present, the initial course of treatment will be administered on an out-patient status. Patients who are not cured by this initial course after an interval of three days will be transferred to a hospital for further treatment.

b. Further penicillin therapy will consist of a total dose of 500,000 units of penicillin. This should be administered in such a way as to provide an adequate penicillin level for a period of more than 24 hours. A satisfactory schedule consists of administration of 30,000 units of penicillin every three hours for 16 doses. The initial two injections may be 40,000 units, to provide full dosage.

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c. Patients who present at the time of the initial examination a concomitant lesion of the skin or mucous membrane which might be syphilitic, will be given sulfonamide therapy for the gonorrheal infection until the study of the patient for syphilis is completed.

d. Determination of cure. Patients hospitalized for uncomplicated gonorrhea should be discharged to duty as soon as they are asymptomatic, usually within 2 or 3 days. The presence of urethral discharge of moderate degree is not considered of sufficient importance to prolong hospitalization, provided the gonococcus cannot be demonstrated by smear or culture. In every case of gonorrhea, follow-up studies should include weekly physical inspection and microscopic examination of urinary discharge or urinary sediment, if feasible, for at least three weeks after penicillin therapy. Prostatic massage or urethral instrumentation will ordinarily not be done. The patient may be considered cured if clinical and laboratory examination as described above are negative at the end of the 3-week follow-up period.

e. The number of patients with acute uncomplicated gonorrhea who are not cured after the treatment outlined in pars a and b will be small. They will fall into two main groups as follows:

- (1) Patients with mild to moderate urethral discharge which is negative for gonococci on smear and culture. These patients will ordinarily respond to adequate urologic management. Follow-up for evidence of relapse of the gonorrheal infection should be especially thorough.
- (2) A much smaller group of patients with persistent mild to profuse urethral discharge which contains gonococci, or with "non-specific" discharges and significant urologic or medical complications which are presumably gonorrheal in origin. If gonococci are present, efforts should be made to determine whether or not the organism is penicillin-sensitive, before further penicillin therapy is given. Sulfonamide therapy, either alone or in conjunction with penicillin, is often useful in these patients.
- (3) The management of the group of patients mentioned in (1) and (2) above will be under the direction of the urologist of the hospital concerned.
- (4) Fever therapy will no longer be available in ETO. It is advisable that the small residuum of patients with significant signs and symptoms of gonorrhea after adequate penicillin therapy

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and competent urologic management be centralized whenever possible. This may be most conveniently carried out in Hospital Centers by informal transfer of such patients to a hospital which the Commanding Officer of the Center may designate as the treatment facility best qualified for the evaluation and treatment of such patients. In particular, great care will be exercised to insure that patients are not evacuated to the Zone of the Interior because of minor signs or symptoms subsequent to treatment for gonorrhea.

5. Follow-up Serologic Tests for Syphilis. Since penicillin therapy for gonorrhea will suppress the development of early syphilis for a variable period, it is essential that follow-up serologic tests for syphilis be performed at three and at six months after treatment is completed.

By order of the Chief Surgeon:

H. W. Doan
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